Appendix P
Colorado Medical Assistance Program
Prior Authorization Procedures and Criteria
For Physicians and Pharmacists

Drugs requiring a prior authorization are listed in this document. The Prior Authorization criteria are based on FDA approved indications, CMS approved compendia, and peer-reviewed medical literature.

Prior Authorization Request (PAR) Process

- Pharmacy PA forms are available by visiting: http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132
- PA forms can be signed by anyone who has authority under Colorado law to prescribe the medication. Assistants of authorized persons can not sign the PA form
- Physicians or assistants who are acting as the agents of the physicians can request a PA by phone
- Pharmacists from long-term-care pharmacies and infusion pharmacy must obtain a signature from someone who is authorized to prescribe drugs before they submit PA forms
- Pharmacists from long-term-care pharmacies and infusion pharmacies can request a PA by phone if specified in the criteria
- All PA's are coded online into the PA system
- Prior Authorizations can be called or faxed to the helpdesk at:

  Phone: 1-800-365-4944

  Fax: 1-888-772-9696

- As of July 1, 2007, ICD-9 codes can be submitted in the point-of-sale system to override certain prior authorizations. To verify an ICD-9 code contact the PAR Helpdesk at:

  Phone: 1-800-365-4944

Medical Supply Items and Medications

- All supplies, including insulin needles, food supplements and diabetic supplies are not covered under the pharmacy benefit, but are covered as medical supply items through Durable Medical Equipment (DME)
- If a medical benefit requires a PA, mail the PA request to:

  Claims and PARs
  P. O. Box 30
  Denver, CO 80201-0030

  DME PAR Phone #: 303-534-0279 or toll free 1-800-237-0757

- To find out more about DME policies call: Anna Davis: 303-866-2113
- Medications given in a hospital, doctor's office or dialysis unit are to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion.

Drug	Criteria	PAR Length
ACETAMINOPHEN CONTAINING PRODUCTS	A prior authorization is required for dosages of acetaminophen containing products over 4000mg/day of acetaminophen.	Variable
ACNE PRODUCTS Topical Tretinoin Products and Isotretinoin Products	Prior authorization is required for all topical tretinoin and isotretinoin products. Payment for topical tretinoin therapy and isotretinoin products will be authorized for the following diagnoses: Cystic acne, disorders of Keratinization, psoriasis, neoplasms, comedonal or acne vulgaris. ➢ *Cystic acne, disorders of Keratinization, psoriasis, or neoplasms*, do **not** require previous trials and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for a one-year period. ➢ The diagnosis of *comedonal* does **not** require previous trial and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for an initial three-month period. IF topical tretinoin therapy is effective after the initial approval period, a prior authorization will be granted for a one-year period. ➢ A diagnosis of *acne vulgaris* **requires** previous trials and treatment failures on antibiotic and /or topical treatments. If criteria are met, a prior authorization will be granted for a one-year period.	See criteria
ADOXA TT AND CK KIT	A prior authorization will only be approved if a client has tried and failed on the generic oral doxycycline or topical clindamycin for a period of 3 or more months in the last 6 months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
ALBUMIN	Must have an FDA approved indication and given in the client's home or in a long-term care facility for approval. The following are FDA approved indications: ➢ Hypoproteinemia ➢ Burns ➢ Shock due to: ▪ Burns ▪ Trauma ▪ Surgery ▪ Infection ➢ Erythrocyte resuspension ➢ Acute nephrosis ➢ Renal dialysis ➢ Hyperbilirubinemia ➢ Erythroblastosis fetalis	One year
ALPHA –1 PROTEINASE INHIBITORS Aralast, Prolastin and Zemaira	FDA approved indication if given in the client's home or in a long-term care facility: ➢ Prolastin: Emphysema associated with Alpha-1 Antitrypsin Deficiency ➢ Aralast: Chronic augmentation therapy in clients having congenital deficiency of Alpha –1 Proteinase Inhibitor with clinically evident emphysema ➢ Zemaira: Chronic augmentation and maintenance therapy in clients with Alpha- 1 Proteinase Inhibitor deficiency with clinically evident emphysema	Lifetime

Drug	Criteria	PAR Length
ALZHEIMER'S AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ANABOLIC STEROIDS Including Androgel	FDA approved indications if given in the client's home or in a long-term care facility: ➢ Wasting AIDS ➢ Hypogonadism in males ➢ Corticosteroid-induced Hypogonadism and Osteoporosis ➢ Turner's Syndrome in females ➢ Delayed puberty in males	One year
ANOREXIENTS (Diet Pills)	**Not Covered**	None
ANTI-ANEMIA DRUGS (Oral and injectable drugs)	**FDA approved indication**: Iron Deficiency Anemia Injectable Drugs [i.e.: Infed (iron dextran), Venofer, Ferrlecit] ➢ Diagnosis of iron deficiency anemia when oral preparations are ineffective or cannot be used. ➢ Must be administered in a client's home or in a long-term care facility	Lifetime
ANTIDEPRESSANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products See additional information for citalopram.	
ANTIEMETICS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ANTIHISTAMINES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ANTIHISTAMINES WITH DECONGESTANTS (Rx)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ANTIHYPERTENSIVES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ANTIPLATELETS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609.	

Drug	Criteria	PAR Length
ATYPICAL ANTIPSYCHOTICS (oral)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products See additional information for Seroquel (quetiapine).	
ATYPICAL ANTIPSYCHOTICS (Injectable) Abilify, Zyprexa Relprevv, Invega Sustenna, Geodon and Risperdal Consta	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client's home.	One year
BACTROBAN Nasal Ointment and Cream (Generic Bactroban Ointment does not require a prior authorization)	**Bactroban Cream** (mupirocin calcium cream) must be prescribed for the treatment of secondarily infected traumatic skin lesions (up to 10 cm in length or 100 cm^2 in total area), impetigo, infected eczema or folliculitis caused by susceptible strains of Staphylococcus aureus and Streptococcus pyogenes. **Bactroban Nasal Ointment** (mupirocin calcium) must be prescribed for the eradication of nasal colonization with methicillin-resistant Staphylococcus aureus in adult patients and health care workers as part of a comprehensive infection control program to reduce the risk of infection among patients at high risk of methicillin-resistant S. aureus infection during institutional outbreaks of infections with this pathogen.	Cream: One year Nasal Ointment: Lifetime
BENLYSTA (belimumab)	A prior authorization may be approved only when documentation has been received indicating that the drug is being administered in the client's home or long-term care facility. The client must also meet the following criteria: • Diagnosis of autoantibody postitive SLE with organ involvement; AND • Incomplete response to standard therapy from at least two of the following therapeutic classes: antimalarials, immunosuppressants and glucocorticoids; AND • Maintenance of standard therapy while on BENLYSTA.	One year
BISPHOSPHONATES (Injectable) Didronel, Boniva, Aredia, Miacalcin, Zemplar, Hectorol, Zometa, Pamidronate, and Ganite	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility or in a client's home.	One year
BISPHOSPHONATES (oral)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
BLOOD PRODUCTS	FDA approved indications if given in the client's home or in a long-term care facility: ➢ Plasma protein fraction; shock due to burns, trauma, surgery; hypoproteinemia; adult respiratory distress syndrome; cardiopulmonary bypass; liver failure; renal dialysis; or hemophilia.	Lifetime

Drug	Criteria	PAR Length
BOTOX / MYOBLOC INJECTION	FDA approved indication if given in the client's home or in a long-term care facility. ➢ *Cervical or Facial Dystonia* ***Not approved for Cosmetic Purposes***	One year
BRAND NAME MEDICATIONS	As of April 1, 2008, providers should use the Colorado Medicaid Pharmacy PAR Form posted on the web site. Medwatch forms are no longer accepted. The DUR Clinical Manager will continue to accept the Brand Name Request Form until July 1, 2008. Only brand name drugs that have a generically equivalent drug (as determined by the FDA) require a prior authorization. Exceptions to the rule include: ➢ The brand name drug has been exempted (see the list below) ➢ When the reimbursement for a brand-name drug is less expensive than the cost of the generic equivalent ➢ The physician is of an opinion that a transition to the generic equivalent of a brand-name drug would be unacceptably disruptive to the patient's stabilized drug regimen ➢ The patient is started on a generic drug but is unable to continue treatment on the generic drug as determined by the patient's physician The following list of drug classes is exempt from the generic mandate rule (no PA is required). Medications used for the treatment of: ➢ Biologically based mental illness defined in 10-16-104 (5.5) C.R.S. ➢ Cancer ➢ Epilepsy ➢ HIV/AIDS	One year
CIALIS (tadalafil)	Cialis will be approved for clients with a documented diagnosis of BPH who have failed a trial of finasteride (at least 3 months in duration) AND either a trial of a nonselective alpha blocker (therapeutic dose for at least two months) OR a trial of tamsulosin (therapeutic dose for at least one month). Documentation of BPH diagnosis will require BOTH of the following: 1. AUA Prostate Symptom Score ≥ 8 AND 2. Results of a digital rectal exam. Cialis will not be approved for any patient continuing alpha-blocker therapy as this combination is contraindicated in this population. Doses exceeding 5mg per day of Cialis will not be approved.	
CITALOPRAM (high dose)	Prior authorization will be required for doses exceeding 40mg/day. Please see the FDA guidance at: http://fda.gov/Drugs/DrugSafety/ucm269086.htm for important safety information.	One year
COUGH AND COLD (Rx)	Client <21 years: covered benefit. A prior authorization is not needed. Client ≥ 21 years must have diagnosis of a chronic condition such as COPD or asthma.	One year

<table>
<tr><th>Drug</th><th>Criteria</th><th>PAR Length</th></tr>
<tr><td>COX-2 INHIBITORS

Celebrex</td><td>Effective September 30, 2004: No PAs will be granted for Vioxx.
Effective April 7, 2005: No PAs will be granted for Bextra.
PA is required for clients who are 64 years of age and younger. Clients over the age of 65 do not require a PA.
A PA will be approved if the COX-2 is prescribed for a FDA approved indication.
<table>
<tr><td>FDA Approved Indication</td><td>Dose and Length of PA</td></tr>
<tr><td>Acute Pain</td><td>Up to 600mg day 1; 200mg BID for no more than 30 days</td></tr>
<tr><td>Dysmenorrhea</td><td>Up to 600mg day 1; 200mg BID. One year approval</td></tr>
<tr><td>Ankylosing spondylitis</td><td>200mg daily; after 6 weeks of 200mg daily dosing if client’s condition has been unresponsive, 400mg daily may be approved. Lifetime approval</td></tr>
<tr><td>Familial Adenomatous Polyposis</td><td>400mg BID. Lifetime approval</td></tr>
<tr><td>Osteoarthritis</td><td>200mg daily; 100mg BID. Lifetime approval</td></tr>
<tr><td>Rheumatoid Arthritis</td><td>100-200mg BID. Lifetime approval</td></tr>
<tr><td>Juvenile Rheumatoid Arthritis</td><td>Up to 100mg BID. 6 month approval</td></tr>
</table></td><td>See chart</td></tr>
<tr><td>DEPO PROVERA / LUNELLE</td><td>FDA approved indication if given in a long-term care facility:
Females: Contraception, uterine bleeding, amenorrhea, endometrial cancer
Males: Sexual aggression / Pedophilia – Only Depo-Provera will be approved
Not approved for administration in the physician’s office – these must be billed through medical.</td><td>One year</td></tr>
<tr><td>DESI DRUGS</td><td>DESI drugs (Drugs designated by the Food and Drug Administration as Less Than Effective Drug Efficacy Study Implementation medications) are not a covered benefit.</td><td></td></tr>
<tr><td>DIABETES MANAGEMENT CLASSES</td><td>This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products</td><td></td></tr>
<tr><td>ELESTRIN GEL</td><td>A prior authorization will only be approved if a client has tried and failed on generic oral estradiol therapy and diagnosed with moderate-to-severe vasomotor symptoms (hot flashes) associated with menopause. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)</td><td>One year</td></tr>
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Drug	Criteria	PAR Length
ERECTILE DYSFUNCTION DRUGS Caverject Cialis Edex Levitra Muse Viagra	Effective January 1, 2006, no drugs will be covered for erectile dysfunction. PAs for Viagra for pulmonary hypertension can no longer be approved. Yohimbine: PAs can no longer be approved for erectile dysfunction. Any PAs for use as a mydriatic agent or a vasodilator (not related to erectile dysfunction) may be approved.	Not available Lifetime
FENTANYL PREPARATIONS Actiq, Fentora, Onsolis and Duragesic Transdermal System	Actiq, Fentora and Onsolis: Approval will be granted if the client is diagnosed with cancer and has already received and is tolerant to opioid drugs for the cancer pain. The PA may be granted for up to 4 lozenges, tablets or soluble films per day. Duragesic Transdermal System: Effective March 4, 2004, a PA is required for doses of more than 1 Patch/2 Days. For all Fentanyl preparations: If the patient is in hospice, the PA will be automatically granted regardless of the number of doses prescribed.	One year
FIBROMYALGIA AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
FLECTOR 1.3% PATCH	A prior authorization will only be approved if a client has tried and failed on Voltaren Gel. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
FLUORIDE PREPARATIONS	Effective February 1, 2008, a prior authorization will not be needed for clients less than 21 years of age. Prior authorization requests for clients 21 years of age and older will be individually reviewed by the state.	N/A

Drug	Criteria	PAR Length
FILGRASTIM/ PEGFILGRASTIM / SARGRAMOSTIM Neupogen, Neulasta and Leukine	Prior authorization is required for therapy with filgrastim, pegfilgrastim or sargramostim. **Prior authorizations for PEGFILGRASTIM will be approved for the following indication if the criterion is met:** Indication: To decrease the incidence of infection due to neutropenia in clients receiving myelosuppresive anti-cancer therapy. ➢ Criterion 1. CBC and platelet count obtained before chemotherapy is administered. **Prior authorizations will be approved for FILGRASTIM AND SARGRAMOSTIM for the following indications if the applicable criteria are met:** Indication: To decrease the incidence of infection due to severe neutropenia caused by myelosuppresive anti-cancer therapy. ➢ Criterion 1. Either the post nadir ANC is less than 10,000 cells/mm^3 or the risk of neutropenia for the client is calculated to be greater than 20% ➢ Criterion 2. Routine CBC and platelet counts twice weekly Indication: Use in patients undergoing bone marrow transplant and for use after bone marrow transplant. ➢ Criterion 1. Routine CBC and platelet counts at least three times weekly for filgrastim and two times weekly for sargramostim. Indication: For patients undergoing peripheral blood progenitor cell collection and therapy. ➢ Criterion 1. Monitoring of neutrophil counts after four days of treatment. Indication: For filgrastim only, for chronic administration to reduce the incidence and duration of clients with congenital neutropenia, cyclic neutropenia or idiopathic neutropenia. ➢ Criterion 1. CBC and platelet count obtained before treatment with filgrastim begins. ➢ Criterion 2. Routine CBC and platelet counts twice weekly during initial four weeks of therapy and during the two weeks following any dose adjustment. Indication: To decrease the incidence of infection due to severe neutropenia in HIV/AIDS clients. ➢ Criterion 1. Evidence of neutropenia Infection exists or ANC is below 750 cells/mm^3 ➢ Criterion 2. ANC is maintained at Approximately 1,000 cells/mm^3 by filgrastim adjustment ➢ Criterion 3. Routine CBC and platelet counts as needed.	One year

Drug	Criteria	PAR Length
FUZEON	If administered in the physician's office or delivered to physician's office, physician must bill as a medical claim on the 1500 claim form **(no PA required).** If administered in the client's home or in a long-term care facility, a prior authorization is required and must meet the criteria below for approval Based on clinical trial data, ENF should be used as part of an *optimized* background regimen for treatment-experienced clients: ➢ For treatment-experienced clients with evidence of HIV-1 replication, treatment should include at least one antiretroviral agent with demonstrated HIV-1 susceptibility on the basis of genotypic/phenotypic *resistance* assays, and *two* "active" antiretroviral agents. o Clients must have limited treatment options among currently commercially available agents. ➢ Clients must be 18 years of age or older with advanced HIV-1 infection, and not responding to approved antiretroviral therapy. ➢ Clients must have a CD4 lymphocyte count less than 100 cells/mm3 and a viral load greater than 10,000 copies/ml (measurement within the last 90 days). Past adherence must be demonstrated based on: ➢ Attendance at scheduled appointments, and/or ➢ Prior antiretroviral regimen adherence, and/or ➢ Utilization data from pharmacy showing client's use of medications as prescribed ➢ Ability to reconstitute and self-administer ENF therapy. At 24 weeks, clients must experience at least ≥ 1 $\log_{10}$ decrease in HIV RNA or have HIV RNA below quantifiable limits to continue treatment with ENF. Clients are not eligible if antiretroviral treatment-naive and/or infected with HIV-2. Pre-approval is necessary Practitioner must either be Board Certified in Infectious Disease, or be an HIV experienced practitioner. Verification must be produced with the prior approval documents. **These guidelines may be modified on the basis of other payer formularies and/or the emergence of new data.**	Six months
GROWTH HORMONES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	

Drug	Criteria	PAR Length
H2 BLOCKERS **Ranitidine capsules and liquid**	**Generic H2 Blockers** do not require a PA except for ranitidine capsules and liquid. Ranitidine capsules: Require the prescribing provider to certify that capsules are "medically necessary" and that the client cannot use the tablets. Ranitidine liquid: A prior authorization will be granted for clients with a feeding tube or who have difficulty swallowing. A prior authorization is not required for children under 12 years of age.	One year
HORIZANT (gabapentil enacarbil)	A prior authorization may be approved for clients meeting all of the following criteria: • Diagnosis of Restless Leg Syndrome; • Therapy failure on at least a one month trial of Mirapex (pramipexole) and Requip (ropirinole); • Incomplete therapeutic response to generic gabapentin. A maximum of one tablet per day will be approved.	
IMPLANON	See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.	
INTRANASAL CORTICOSTEROIDS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
IVIG	Clients must have one of the following conditions: ➢ Immunodeficiency disorders: 1. Common Variable Immunodeficiency (CVID) 2. Severe Combined Immunodeficiency (SCID) 3. X-Linked Agammaglobulinemia 4. X-Linked with Hyperimmunoglobulin M (IgM) Immunodeficiency 5. Wiskott-Aldrich Syndrome 6. Pediatric Human Immunodeficiency Virus (HIV): ▪ Clients are less than 13 years of age and CD-4 Count is > 200/mm3 ➢ Neurological disorders: 1. Guillain-Barre' Syndrome 2.Relapsing-Remitting Multiple Sclerosis 3. Chronic Inflammatory Demyelinating Polyneuropathy 4.Myasthenia Gravis 5.Polymyositis and Dermatomyositis ➢ Chronic Lymphocytic Leukemia (CLL) ➢ Autoimmune Neutropenia (AN): 1. Absolute neutrophil count is less than 800 mm And 2.Has recurrent bacterial infections ➢ Autoimmune Hemolytic Anemia (AHA) ➢ Liver or Intestinal Transplant	One year One year CLL: One year AN: 6 months AHA: 5 weeks ITP: 5 days

Drug	Criteria	PAR Length
	➢ Idiopathic Thrombocytopenic Purpura (ITP): 1. Preoperatively for clients undergoing elective spleenectomy with platelet count < 20,000 2. Clients with active bleeding & platelet count <30,000. 3. Pregnant women with platelet counts <10,000 in the third trimester. 4. Pregnant women with platelet count 10,000 to 30,000 who are bleeding.	
KALYDECO	Kalydeco will only be approved if all of the following criteria are met: 1. Client has been diagnosed with cystic fibrosis AND 2. Client is an adult or pediatric patient 6 years of age or older AND 3. Documentation has been provided to indicate a G551D mutation in the CFTR gene AND 4. Documentation has been provided that baseline ALT and AST have been accessed and are within 2x normal limits (AST and ALT should be examined every 3 months for the first year and annually after that). Kalydeco will only be approved at doses no more than 150 mg twice daily. Prior Authorizations need to be obtained yearly. Kalydeco will not be approved for clients who are concurrently receiving rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, or St. John's Wort.	One year
LEUKOTRIENES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
LIPIDS/AMINO ACIDS/PLASMA PROTEINS	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime
LHRH/GnRH Luteinizing Hormone Releasing Hormone/Gonadtropin Releasing Hormone	Must be given in the client's home or in a long-term care facility. Prior authorization will be granted for FDA Approved Indications Only: ➢ **Lupron (leuprolide):** Prostate Cancer, Endometriosis, Uterine Leiomyomata (fibroids), Precocious Puberty ➢ **Zoladex**: Breast Cancer, Endometriosis, Endometrial Thinning, Prostate Cancer ➢ **Trelstar**: Palliative treatment of Advanced Prostate Cancer ➢ **Eligard:** Palliative-treatment of Advanced Prostate Cancer ➢ **Viadur:** Palliative treatment of Advanced Prostate Cancer ➢ **Vantas**: Palliative treatment of Advanced Prostate Cancer	One year
LYRICA pregabalin	Effective May 1, 2012, for clients with no epilepsy diagnosis in the last two years (as confirmed by SMART PA), Prior Authorization will be required for LYRICA prescriptions requiring more than 3 capsules per day or for prescriptions requiring doses greater than 600mg per day.	One year

Drug	Criteria	PAR Length
MAKENA Hydroxyprogesterone caproate injection	Makena will be approved for clients that meet the following criteria • The drug is being administered in the home or in long-term care setting; • Client has a Singleton pregnancy and a history of singleton spontaneous preterm birth; • Therapy is being initiated between 16 weeks gestation and 20 weeks, 6 days gestation. • Dose is administered by a healthcare professional; • Compounded hydroxyprogesterone product is contraindicated.	
MOXATAG	A prior authorization will only be approved if a client is allergic to inactive ingredients in immediate release amoxicillin.	One year
MULTIPLE SCLEROSIS INTERFERON PRODUCTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
NEWLY APPROVED PRODUCTS	Newly marketed drugs may be subject to prior authorization for a minimum of nine months following FDA marketing approval. Initial approval criteria will include non-preferred criteria (for drugs within a reviewed PDL class); or FDA approved indications, dose, age and place in therapy. For drugs in PDL classes, the next class annual review will include the new agent. For non-PDL drugs, criteria shall be reviewed at the quarterly DUR meeting closest to the nine month minimum.	
NEXPLANON	See PHYSICIAN ADMINISTERED DRUGS. Not a covered pharmacy benefit when implanted in the clinic or hospital outpatient center.	
OPHTHALMIC ALLERGY PRODUCTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
OPIOIDS Long Acting – Oral Opioids	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ORACEA	A prior authorization will only be approved if all of the following criteria are met: ➢ client has taken generic doxycycline for a minimum of three months and failed therapy in the last 6 months (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions), ➢ client has been diagnosed with rosacea with inflammatory lesions, and ➢ client is 18 years of age or older	16 weeks

Drug	Criteria	PAR Length
OTC PRODUCTS	Medical Necessity ➢ Aspirin, Insulin and Plan B are covered without a PA ➢ Prilosec OTC: *See Proton Pump Inhibitor's section* ➢ Guaifenesin 600mg LA is covered for clients having an abnormal amount of sputum ➢ Quinine Sulfate *is no longer covered* for leg cramps ➢ Herbal products are not a benefit except for cranberry tablets, which are covered for urinary tract infections ➢ Diabetic needles and supplies are not a prescription benefit and should be billed as supply ➢ Broncho saline is not covered- refer to Sodium Chloride section ➢ Cough and Cold Products must have a diagnosis of a chronic respiratory condition for which these medications may be prescribed or otherwise be medically necessary ➢ Antihistamine (w/ decongestant) must have a diagnosis of seasonal or perennial allergic rhinitis or chronic sinusitis or otherwise be medically necessary ➢ Nicomide is approved for acne *Nursing Facilities: Please provide OTC floor stock list.* *Clients with Erythema Bullosum (EB) can receive any OTC medication with a prior authorization.*	One year
OVERACTIVE BLADDER AGENTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
OXSORALEN	Approval will be granted with diagnosis of: Myosis; Fungoides; Psoriasis or Vitiligo	One year
PHYSICIAN ADMINISTERED DRUGS	Medications given in a hospital, doctor's office or dialysis unit are only to be billed directly by those facilities as a medical item. IV Fluids, meds, etc. may be billed by the pharmacy when given in a long-term care facility or by home infusion following prior authorization approval. Prior authorizations will be approved based upon documentation of the location for administration.	
PROMETHAZINE	A Prior authorization is required for all routes of administration for clients under the age of two. Children under the age of two should not use Promethazine. Promethazine is contraindicated in such patients because of the potential for fatal respiratory depression.	One year
PROPECIA	***Not covered for hair loss***	One year

Drug	Criteria	PAR Length
PROTEASE INHIBITORS TO TREAT HEPATITIS C	Prior authorization for Protease inhibitors used to treat chronic hepatitis C will only be approved for clients meeting all of the following criteria: • Age of 18 years or older; • With confirmed Genotype 1A or 1B Chronic Hepatitis C with compensated liver disease (including cirrhosis); • Concurrently taking both ribavirin and pegylated interferon compliant with product labeling; • Following a negative pregnancy test (for women under 45 years); AND • Not currently taking inducers of CYP 3A4/5 such as rifamixin, rifabutin, phenytoin, carbamazepine or phenobarbital. Manufacturer guidelines for response-guided therapy and treatment futility shall be followed. Viral loads must be taken per manufacturer guidelines and reported to the Colorado Medicaid manual PA review team (faxed to 303-866-3590). Therapy will be limited to 12 weeks for telapravir and 44 weeks for boceprevir. Failure to follow manufacturer guidelines or maintain compliance will result in discontinuation or prior authorization.	
PROTON PUMP INHIBITORS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
PULMONARY ARTERIAL HYPERTENSION THERAPIES	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
REBATE DISPUTE DRUGS	Medical necessity.	One year
RESPIRATORY INHALANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
REQUIP XL	A prior authorization will only be approved if a client has tried and failed on generic immediate release ropinirole for a period of 3 or more months in the last 6 months and the client has a diagnosis of Parkinson's disease. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions) **Grandfathering:** Clients who have been previously stabilized on Requip XL can receive approval to continue on the medication for one year if medically necessary.	One year

Drug	Criteria	PAR Length
REVIA/NALTREXONE	As of March 1, 2007, a PA is no longer required.	N/A
RYBIX ODT	Rybix will be approved for clients who are unable to swallow oral tablets or for clients who are unable to absorb oral medications.	One year
RYZOLT	A prior authorization will only be approved if a client has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
SANDOSTATIN	Approved for: acromegaly; carcinoid tumors; and vasoactive intestinal peptide tumors.	Lifetime
SEDATIVE/HYPNOTICS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
SEROQUEL (quetiapine) at doses < 150mg/day	Low-dose quetiapine (<150mg/day) is only FDA approved as part of a drug titration schedule to aid patients in getting to the target quetiapine dose. Prior authorization will be required for quetiapine < 150mg per day for longer than 30 days, except for utilization (when appropriate) in clients age 65 years or older.	One year
SILENOR	A prior authorization will be approved if a client meets one of the following criteria: • Contraindication to preferred oral sedative hypnotics (Lunesta, zaleplon and zolpidem) • Medical necessity for doxepin dose < 10 mg • Age greater than 65 years old or hepatic impairment (3 mg dose will be approved if this criteria is met)	One year
SIMVASTATIN 80mg	Effective December 1, 2011, simvastatin 80mg dose products will only be covered for clients who have been stable for more than 12 months at that dose. Providers should consider alternate preferred statins in clients who have not met cholesterol goals on simvastatin at doses up to 40mg per day. Please refer to the FDA communication entitled, "FDA Drug Safety Communication: New restrictions, contraindications, and dose limitations for Zocor (simvastatin) to reduce the risk of muscle injury" for updated guidance on contraindications, dose limits and relative LDL lowering doses of alternatives.	One year
SKELETAL MUSCLE RELAXANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
SMOKING CESSATION (Rx & OTC)	Clients should be referred to the QuitLine or another behavior modification program. The name of that program should be included on the prior authorization form . Medical Assistance Program will pay for only **one product** at a time but a client may receive multiple strengths of a product or multiple products during the two 90-day paid benefit periods.	Two 90-day paid benefits per year

Drug	Criteria	PAR Length
SODIUM CHLORIDE For inhalation use	Broncho Saline is **not** covered as a drug benefit. **Sodium Chloride 0.9%:** Only the 3cc unit dose is covered, if the client is sight-impaired and used in the client's home. **Sodium Chloride 3% and 7% vial:** Nebulizer treatment for clients with cystic fibrosis and other pulmonary diseases for mucolytic therapy done in the home. All other requests for sodium chloride (inhalation use) must be billed through medical.	Lifetime
SOLARAZE 3% GEL	A prior authorization will only be approved if the client has a diagnosis of Actinic Keratoses (AK).	One year
STATINS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
STIMULANTS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
SUBOXONE and SUBUTEX	Suboxone will be approved if the following criteria are met: ➢ The prescriber is authorized by the manufacturer to prescribe Suboxone ➢ The client has an opioid dependency ➢ The client is not currently receiving an opioid or opioid combination product. ★Suboxone will not be approved for the treatment of pain. ★Opioid claims will not be allowed for clients with a claim for Suboxone in the preceding 30 days. ★Suboxone will not be approved for more than 24mg of buprenorphine /day Subutex will be approved if all of the following criteria are met: ➢ The prescriber is authorized by the manufacturer to prescribe Subutex ➢ The client has an opioid dependency ➢ The client is pregnant or the client is allergic to Naloxone ★Subutex will not be approved for the treatment of pain. ★Subutex will not be approved for more than 24mg/day	One year

Drug	Criteria	PAR Length
SYNAGIS	**Prior Authorization requests for Synagis must be submitted by fax using the Synagis Prior Authorization Form found at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.** **A Prior Authorization can be approved if:** The medication will be administered in the client's home; the client is under age 2 at the start of the current RSV season (as determined by the CDC); and who meets one of the following: 1. Diagnosis of Chronic Lung Disease (CLD) AND having one for more of the following clinical needs during the previous 6 months: a. Supplemental oxygen; b. Regular use of inhaled or oral bronchodilators; c. Recent use of corticosteroid therapy; or d. Regular or intermittent use of diuretics to treat pulmonary disease. ***Up to five (5) monthly doses will be approved.** 2. Diagnosis of Interstitial Lung Disease and/or Neuromuscular disease which impacts pulmonary function *** Up to five (5) monthly doses will be approved.** 3. Any infant or child under the age of 2 who has a diagnosis of congenital heart disease and meets any of the following criteria: a. Receiving medication to control congestive heart failure (diuretics, antihypertensives); b. Suffer moderate to severe pulmonary hypertension; or c. Suffer Cyanotic Heart Disease. *** Up to five (5) monthly doses will be approved.** 4. Any infant up to 6 months of age, born 29 to less than 32 weeks gestation *** Up to five (5) monthly doses will be approved.** 5. Any infant up to 12 months of age, born at 28 weeks or less gestation *** Up to five (5) monthly doses will be approved.** 6. Any infant younger than 3 months of age at the start of the RSV season, born at 32 to less than 35 weeks gestation and meets one of the following risk factors: a. Currently attends day care; b. Has a sibling younger than 5 years of age; c. Congenital abnormalities of the airway; or d. A neuromuscular condition that compromises handling of respiratory secretions. ***Up to three (3) monthly doses will be approved or until the child reaches 3 months of age.** 7. Infants up to 2 years of age with hemodynamically significant heart disease defined as having one or more of the following: a. Infants receiving medication to control congestive heart failure; b. Infants with moderate to severe pulmonary hypertension; or c. Infants with cyanotic heart disease. *** Up to five (5) monthly doses will be approved.**	See individual approval criteria

Drug	Criteria	PAR Length
TARGETED IMMUNE MODULATORS FOR RA (self-administered)	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
TARGETED IMMUNE MODULATORS FOR RA (iv infused products)	Remicade (infliximab) will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ clients with ulcerative colitis ➢ clients with rheumatoid arthritis who have tried and failed therapy with both Enbrel and Humira ➢ clients with psoriatic arthritis ➢ clients with ankylosing spondylitis ➢ clients with juvenile idiopathic arthritis ➢ clients with plaque psoriasis ➢ clients with Crohn's Disease Orencia (abatacept) – will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ Clients with moderate to severe rheumatoid arthritis who have failed therapy with both Enbrel and Humira ➢ Clients with moderate to severe juvenile idiopathic arthritis Rituxan (rituximab) - will be approved for clients who are receiving the infusion in their home or in long-term care and who meet one of the following: ➢ Clients with moderate to severe rheumatoid arthritis who have tried and failed both Enbrel and Humira ➢ Clients with Chronic Lymphocytic Leukemia ➢ Clients with Non-Hodgkins Lymphoma	One year
THROMBOLYTIC ENZYMES	Approved for **IV Catheter Clearance or Occluded AV Cannula** if given in client's home or long term care facility.	One year
TOPICAL IMMUNOMODULATORS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
TPN PRODUCTS	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	Lifetime

Drug	Criteria	PAR Length
TRAMADOL	Tramadol is not approved for more than 400mg/day.	N/A
TRIPTANS	This class is part of the Preferred Drug List (PDL). Please refer to the PDL posted at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485609 for the Preferred Products	
ULTRAM ER	A prior authorization will only be approved if a client has tried and failed on the maximum dose of tramadol (400mg per day) for a period of 3 or more months in the last six months. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
VACCINES Flu, Hepatitis B and Pneumonia	Effective 10/21/09, the H1N1 vaccine will be a covered benefit. All other vaccines must be bill on Colorado 1500 form as a medical expense unless administered in long-term care facility. Any vaccine can be approved by prior authorization if a client is living in a long-term care facility. (Not a covered benefit for regular patients – only long-term care facilities).	One year
VERIPRED	A prior authorization will only be approved if a client has tried and failed on a generic prednisolone product. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
VERSED Midazolam	Approved if given in the client's home or in a long-term care facility and given for: ➢ Preoperative sedation or anesthesia ➢ Terminally ill clients with Cancer ➢ Client with Erythema Bullosum (EB) –approval for one year	One month
VIMOVO	Approved if client has failed treatment with two Preferred Proton Pump Inhibitors within the last 24 months, and has one of the following diagnoses: ➢ Ankylosing spondylitis in patients at increased risk of developing NSAID induced ulcers; ➢ Osteoarthritis in patients at increased risk of developing NSAID induced ulcers; ➢ Rheumatoid arthritis in patients at increased risk of developing NSAID induced ulcers.	One year

Drug	Criteria	PAR Length
VITAMINS (Rx)	**Prescription Vitamins (except for prenatals) will be authorized for:** ➢ ESRD, CRF, renal insufficiency, diabetic neuropathy or renal transplant ➢ Clients under the age of 21 with a diagnosis disease that prohibits the nutrition absorption process as a secondary effect of the disease. ➢ Clients with Erythema Bullosum (EB) (continued on next page) **Hydroxocobalamin Injections** In addition to the above general vitamin criteria, approval can also be given for methylmalonic academia (MMA). **Cyanocobalamin Injections** In addition to the above general vitamin criteria, approval can also be given for vitamin B12 deficiency. **Folic Acid Vitamins (exceptions exist for Folic Acid 1mg, see below)** In addition to the above general vitamin criteria, approval can also be given for folic acid vitamins if one of the following criteria is met: ➢ Currently taking Methotrexate or Alimta ➢ A diagnosis of folic acid deficiency (megaloblastic and macrocytic anemia are the most common). Some drugs or other conditions may cause deficiency -- Approval will be granted for these indications IF the client has current folic acid deficiency and documented by the provider. ➢ **For Female Clients:** Approval will be granted for the prevention of a neural tube defect pregnancy and for the prevention of miscarriages. ➢ Homocysteinemia ➢ Sickle cell disease **Cyanocobalamin/Folic Acid/Pyridoxine** In addition to the above general vitamin criteria, approval can also be given for clients: ➢ with Homocysteinemia or Homocystinuria ➢ on dialysis ➢ with or at risk for cardiovascular disease **Deplin** approved for depressed clients who are currently taking antidepressants and are partial or non-responders **Metanx** approved for clients with non-healing diabetic wounds **Effective November 1, 2009, Prenatal Vitamins are a regular benefit for all female clients. Prenatal vitamins are not covered for male clients.** **Effective November 1, 2009, Folic Acid 1mg does not require a prior authorization for female clients.** **Prescription Vitamin D and Vitamin K products do not require a prior authorization.**	One year

Drug	Criteria	PAR Length
VIVITROL	Approval will be given if administered in the client's home or in a long-term care facility. If given in the hospital or physician's office, the claim must be billed as a medical expense.	One year
VUSION OINTMENT	A prior authorization will only be approved if a client has failed on an OTC antifungal **and** a generic prescription antifungal. (Failure is defined as: lack of efficacy, allergy, intolerable side effects or significant drug-drug interactions)	One year
XENICAL	Effective 5/1/2008, Xenical is not covered.	N/A
XOLAIR	A prior authorization will only be approved as a pharmacy benefit when the medication is administered in a long-term care facility. Medications administered in a physician's office must be billed as a medical expense. Because this medication has a Black Box warning requiring the administration under the supervision of a physician, a PA will not be approved if administered in a client's home.	One year